SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Filing at a Glance

Company: Knights of Columbus

Product Name: Application 600D 1-09	SERFF Tr Num: FRCS-125601792	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 38674
Sub-TOI: L08.000 Life - Other	Co Tr Num: 4931	State Status: Approved-Closed
Filing Type: Form	Co Status: None	Reviewer(s): Linda Bird
	Author: Kevin Wiggs	Disposition Date: 04/18/2008
	Date Submitted: 04/11/2008	Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: KOFC/95

Project Number: 95

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/18/2008

State Status Changed: 04/18/2008

Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Submitted to the domicile state (CT) on or about this same date.

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Filing Description:

The Knights of Columbus is a fraternal benefit society.

This form is new and is not intended to replace any previously approved form.

This application will become the Society's "standard" application, to be used with all single life 2001 CSO products previously approved for use, and approved in future filings. The previously approved forms and their approval dates are listed in the chart below:

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Form Number - Form Description - Approval Date

801-AR 1-08 - Life Paid Up at Age 100 - 8/13/07

811-AR 1-08 - Single Premium Life Insurance – 10/26/07

822-AR 1-08 - Life Paid Up at Age 65 – 3/3/08

829-AR 1-08 - 20 Year Payment Life – 2/13/08

851-AR 1-08 - Term Insurance Contract – 2/22/08

875-AR 1-08 - Annual Renewable Term - 4/3/08

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Our fee of $20 has been sent by EFT on this same date.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

Kevin Wiggs, Compliance Specialist
1020 Central
Kansas City, MO 64105

kevin.wiggs@firstconsulting.com
(800) 927-2730 [Phone]
(816) 391-2755[FAX]

Filing Company Information

Knights of Columbus
1 Columbus Plaza
New Haven, CT 06507-3326
(203) 752-4266 ext. [Phone]

CoCode: 58033
Group Code:
Group Name:
FEIN Number: 06-0416470

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	AR fee of $20 per form.
Per Company:	No

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
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Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Knights of Columbus	$20.00	04/11/2008	19495327

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	04/18/2008	04/18/2008

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Disposition

Disposition Date: 04/18/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		No
Supporting Document	Application		No
Supporting Document	COC		Yes
Supporting Document	Auth		Yes
Supporting Document	RDB		Yes
Form	Insurance Application		Yes

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Form Schedule

Lead Form Number: 600D-AR 1-09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	600D-AR 1-09	Application/ Enrollment Form	Insurance Application	Initial			600D-AR 1-09.pdf

Home Office Use

KNIGHTS OF COLUMBUS

A FRATERNAL BENEFIT SOCIETY
1 Columbus Plaza
New Haven, CT 06510-3326
INSURANCE APPLICATION

Use space below for plate or Agent's name and code.
(This is for General Agent's use only.)

□ GPO □ YPO Contract Number_____

Is the applicant a member of Knights of Columbus? Yes □ No □ (If yes, indicate □ associate member or □ insurance member. If no, application for membership must be made and approved by council.)

PRINT ANSWERS TO ALL QUESTIONS.

1. Name of Applicant: (last-first-middle initial)

2. (a) Council No. (b) Membership No. (c) Social Security No. of Applicant:

3. (a) Date of birth: (mo. day yr.)

INFORMATION CONCERNING PROPOSED INSURED

4. (a) Legal Name: (last-first-middle initial) (b) Sex

5. (a) Maiden Name: (b) Relationship to Applicant:

6. Address Street

City State Zip Code

7. (a) Date of Birth: (mo. day yr.) (b) Issue Age: (c) Place of Birth:

8. □ Single □ Married □ Widowed □ Divorced

9. Social Security No. of Insured: _____

(a) Telephone No. (Day): (___) _____

(b) Telephone No. (Evening): (___) _____

(c) Email Address:

Owner:
Unless otherwise designated below, the owner of adult insurance is the proposed insured and the owner of juvenile insurance is the applicant. In the event of the death of the owner prior to the termination of the Contract, ownership shall pass to the contingent owner designated below:

Owner_____

Relationship to Insured_____

Address of Owner_____

City State Zip Code

Social Security Number or E.I.N. of Owner
(Please complete W-9 Form.)

Contingent Owner: _____

Payor:
Premium Payor's name and Address, if different from Owner: (For EFT/MAC, please use name on voided check.)

10. Premium Payable: $_____
$_____Amount Paid Herewith: If even dollar premium, □ check here and indicate no amount in section 12.

□ Ann. □ M.A.C./E.F.T. **Withdrawal Day:** _____
Existing MAC Policy (ies) _____

□ S.A. □ Military Allotment (branch of service) _____
□ Q.A. □ Combined Billing □ Salary Deduction

11. **(a) Plan Description**: **(b) Plan Code:**

12. **Face Amount: $**_____
If even dollar premium, leave blank.

13. Indicate riders to be included:

□ Waiver of Premium

□ Accidental Death $_____ Amount

□ Guaranteed Purchase Option $_____ Amount

□ Payor Benefit (juvenile contract only) – See Declaration of Insurability below.

□ _____Year Decreasing Term $_____Initial Amount

□ Ten Year Level Term $_____Amount (Insured)

□ Ten Year Level Term $_____Amount (Spouse)

□ IPR _____Yrs. _____Units (Insured)

□ IPR _____Yrs. _____ Units (Spouse)

□ Child Rider $ _____ Amount

□ SDPUA Rider $ _____ Amount

□ 20 Year Term Rider $_____Amount (Insured)

□ 20 Year Term Rider $_____Amount (Spouse)

□ Additional Protection Benefit $_____Amount

□ BGPO $_____Amount

□ Spouse's Contract's Waiver of Premium Rider

□ Youth Purchase Option Rider $_____ Amount

□ Other Rider _____

□ Other Rider _____

□ Other Rider _____

14. Any dividends payable under the insurance contract hereby applied for are to be:

□ paid in cash
□ applied to reduce premium
□ held at interest
□ applied to purchase paid-up additions
□ paid-up additions used as Inside Additions

15. In event of a default in payment of any premium due on the insurance contract issued, shall the automatic premium loan provision, if applicable, be effective in lieu of any nonforfeiture option? Yes □ No □

16. Beneficiary -- May Complete Form 113A.

Primary _____ Relationship to Insured _____

Contingent _____ Relationship to Insured _____

Unless otherwise directed, beneficiaries for insurance provided by Child Rider are stated in rider.

17. **Remarks:**

_____

_____

_____

_____

_____

DECLARATION OF INSURABILITY

1. **List proposed insured and, if applicable, payor (for Payor Benefit Rider only) spouse, children and stepchildren under 18 years of age. Attach a separate sheet, if needed. All questions must be answered for each person listed**.

First Name	Sex	Date of Birth	Height	Weight	Total Insurance in Force
Proposed Insured					
Payor (If Payor Benefit is applied for)					
Spouse					

First Name	Sex	Date of Birth	Height	Weight	Total Insurance in Force
Child					
Child					
Child					

2. Has **any person named in Question 1** ever used tobacco or tobacco substitutes? Yes □ No □

If yes, give dates of last use below. Proposed insured(s) initial here_____.

Cigarettes	**Cigars**	**Pipe**	**Snuff**	**Chewing tobacco**	**Patch, gum or any nicotine substitute**
mo.___ yr.___	mo.____ yr.____	mo.____ yr.____	mo._____ yr._____	mo._____ yr._____	mo._____ yr. _____

All Questions must be answered for each individual listed in Question 1.	Yes	No	Give details below for "yes" answers, including question number and person. If needed, use the space provided in number 12 or an attached separate sheet.
3. a. Are there any existing life insurance or annuity contracts on the life of the applicant?			
b. Is the insurance applied for intended to replace any existing insurance or annuities with the Knights of Columbus or another insurer?			
If the answer to either question is yes, please complete Section 14.			
4. a. Are negotiations now pending for life or health insurance on any of the proposed insureds?			
b. Has any proposed insured been declined, postponed or rated for life or health insurance or reinstatement thereof?			
c. Has any proposed insured ever made claim for sickness, accident or pension benefits?			
d. Has any life, accident or health insurance policy issued on any proposed insured been cancelled by the issuer or the renewal thereof been refused?			
5. a. Is any proposed insured contemplating making or in the past three years has any proposed insured made flights as a pilot, student pilot, crew member, or flights in other than commercial planes? If yes, complete Aviation Questionnaire.			
b. Is any proposed insured contemplating engaging in or in the past three years has any proposed insured engaged in any type of scuba diving or sky diving, racing, rodeo activities or hang gliding? (If yes, complete questionnaire.)			
c. Has any proposed insured recently traveled overseas, or is foreign travel planned or contemplated?			
6. Has **any person named in Question 1** ever received treatment, attention or advice from any physician or other practitioner for, or been told by any physician or other practitioner that such person has or had:			
a. Tuberculosis, asthma, emphysema, COPD, pneumonia or other lung disease or disorder?			
b. Stroke, fainting spells, epilepsy, paralysis, depression or mental disorder, dementia, Alzheimer's, autism, nervous system or other brain disorder?			

All Questions must be answered for each individual listed in Question 1.	Yes	No	Give details below for "yes" answers, including question number and person. If needed, use the space provided in number 12 or an attached separate sheet.
c. Ulcers, colitis, rectal disorder, indigestion or other disorder of the esophagus, stomach, intestines, liver or gallbladder?			
d. Cancer, tumors, disorder of the blood or lymph glands, or endocrine disorder?			
e. Diabetes, sugar, albumin, pus or blood in the urine or other kidney or bladder disorder?			
f. Disease of the heart or blood vessels, chest pains, shortness of breath, heart enlargement, high or low blood pressure, abnormal heart rhythm or palpitations?			
g. Arthritis, gout, multiple sclerosis, or disorder of the muscles or bones?			
h. Disease or disorder of the ears, eyes, nose or throat?			
i. Disorder of the prostate, reproductive organs or breasts?			
7. Has any person named in Question 1 received treatment from any physician, or other practitioner for, or been told by any physician, other practitioner or counselor that such person has or had, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any Disorder of the immune system?			
8. Has any person named in Question 1 been hospitalized or consulted a physician or suffered from any illness, disease or syndrome not listed above, or is any such person taking any medication not previously listed?			
9. Has any person named in Question 1 ever been advised by a health professional to seek treatment for, been treated for the excessive use of alcohol, narcotics or other habit forming drugs or been convicted of or plead guilty to a drug or alcohol related offense?			
10. Within the past three years, has any person named in Question 1 had a license suspended or had a moving traffic violation? (a) Driver's License: _____ (b) State of License: _____			

11. **Primary Care Physicians or Health Facilities:**

Name of Primary Care Physician or Facility	Name of Specialist
Street Address	Street Address
City State Zip Code	City State Zip Code
Telephone Number	Telephone Number
Date last seen: _____ Reason last seen: _____	Date last seen: _____Reason last seen: _____

12. Additional remarks in answer to Questions 3 – 11: _____

13. **All Present Occupations**: **Exact Duties in Each**:

14. List all life insurance, annuities and long term care policies on **any** proposed insured (including pending applications and reinstatements).

Company/Person Insured	Face Amount	Accidental Death Amount	Year Issued	List Contract Number if K. of C.

15. Family history: (any history of diabetes, cancer, high blood pressure, heart, kidney disorder, mental illness or suicide),

	Age	If Living State of Health (if poor, give reason)	If Deceased Age at Death	If Deceased Cause of Death
Father				
Mother				
Brothers and Sisters				

16. Citizenship: □United States □Canada (provide SIN) □Other (provide country and tax I.D. number)

(1) I agree that the statements and answers contained in this application are representations and not warranties and are complete and true to the best of my knowledge and belief. **The Knights of Columbus shall not be bound by any information that is not set out in writing in this application.**

(2) I agree that the Charter, Constitution and Laws of the Knights of Columbus now in effect or hereafter enacted including any change in the method or amount of insurance premiums, shall be binding upon me and the beneficiary.

(3) I agree that, except for coverage which may be provided in the Temporary Insurance Agreement, no insurance will be in force because of this application until it has been approved and the minimum required premium has been paid to the Knights of Columbus.

(4) I agree that the insurance hereby applied for shall be cancelled, if the applicant is a candidate for membership and has not been initiated into the First Degree of the Knights of Columbus within 90 days of the commencement of Temporary Insurance.

Signed at _____this_____day of_____, _____
City State Zip Code Year

Applicant's
Signature_____

Proposed Insured's
Signature_____
(If other than applicant)

Spouse's Signature
If covered under rider_____

Owner's
Signature_____
(If other than applicant or proposed insured**)**

Witness_____
Signature and I.D. Number of Writing Agent

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A) To assist the Knights of Columbus in underwriting an application for insurance, I hereby authorize those persons or organizations listed in section B of this Authorization who possess medical or non-medical information concerning me or my children and stepchildren to permit the Knights of Columbus or its representatives, including, but not limited to: physicians, paramedics, teleunderwriters and consumer reporting agencies; to view, to copy, to be furnished a copy or to be given details of all such information. In addition to other medical or non-medical information, this Authorization applies to any information about psychiatric, drug or alcohol abuse treatment. **Please note that the term "non-medical information" consists of information obtained from a consumer investigative report which would pertain to such items as: confirmation of age, residence, marital status, employment, information as to character, general reputation, personal characteristics, avocation and mode of living.**

B) Those persons or organizations authorized to disclose medical or non-medical information concerning me or my children and stepchildren are: licensed physicians, medical practitioners, paramedics, teleunderwriters, hospitals, clinics or other medical or medically related facilities, government agencies regulating motor vehicles, insurance and reinsurance companies, consumer reporting agencies and the Medical Information Bureau.

C) Notwithstanding the provisions of sections A and B of this Authorization, the Medical Information Bureau may release information only to the Knights of Columbus.

D) I also authorize the Knights of Columbus to release any information regarding me, my children and stepchildren or our health to: the Medical Information Bureau; any company to which my application is submitted for reinsurance purposes; my Knights of Columbus agents; and to other life insurance companies with whom I have policies or to whom I may apply for insurance, or to whom a claim for benefits may be submitted.

E) I authorize the Knights of Columbus to obtain an investigative consumer report on me. I understand that I may request to be interviewed in connection with the preparation of such a report.

F) I acknowledge receiving and reading the notices regarding the Fair Credit Reporting Act, the Medical Information Bureau, Description of Information Practices and Fraud Warning.

G) This Authorization expires two years from the date shown below unless sooner revoked by writing to us at P. O. Box 1670, New Haven, Connecticut 06510-3326. A photocopy of this signed Authorization shall have the same validity as the original. I understand that I am entitled to receive a copy of this Authorization.

Signature_____
(Parent if proposed insured is under 18)

_____
(Spouse if coverage applied for)

In presence of:

_____ Date_____
Witness

I request that I be interviewed in the event an investigative consumer report is prepared in connection with the application. (Please initial here_____.)

WRITING AGENT'S REPORT

1. Does the proposed insured have any existing life insurance or annuity contracts? ____ Yes ____ No.

   Has any life insurance or annuity contract either in force or applied for on the life of the proposed insured terminated or is termination of such insurance or annuity contemplated as a result of the issuance of the life insurance contract applied for? Yes □ No. □

   If the answer to either question is yes, have you complied with the requirements of the Order and your state with regard to this replacement? Yes □ No □ (Give full details under Remarks.)

2. Has any application been previously submitted to the Knights of Columbus on the life of any member of this family? Yes □ No □
   Contract No. (s)_____

3. Have you any information not fully set forth in this application regarding habits, character and reputation, or state of health of any member of this family which might affect the decision of the Knights of Columbus regarding the issuing of insurance? Yes □ No □

4. Did you personally observe every proposed insured member of this family? Yes □ No □

5. How well do you know the proposed insured or family?
   - □ Met very recently.
   - □ Known slightly for _____ years.
   - □ Known well for _____ years.
   - □ Are you a relative? Yes □ No □

     Relationship_____

6. Are all children, stepchildren or legally adopted children under attained age 18 years listed in answer to question 1 of page 2 of this application?
   Yes □ No □ (If not, explain fully under remarks.)

7. If proposed insured is a juvenile, indicate number of brothers ___, sisters ___. Are they insured: Yes □ No □
   If yes, indicate amount of insurance on each.
   _____
   If no, explain below.

8. If proposed insured is the applicant's spouse, indicate amount of insurance on applicant._____

9. Applicant's yearly income $_____ Net Worth_____
   Spouse's yearly income $_____ Net Worth_____

10. What is the purpose of the applied for insurance?
    _____
    _____
    _____

Have you issued a receipt with this application? Yes □ No □

I certify that a copy of the notice pursuant to the Fair Credit Reporting Act, the Notice Regarding the Medical Information Bureau, the Description of Information Practices and Fraud Warning were delivered to the applicant by the undersigned on _____.

I further certify that on the date shown below: (a) I have personally seen the proposed insured; (b) I have separately and fully asked each question on pages 1 through 5 of the application and I have truly and accurately recorded the information supplied by the proposed insured, and the applicant if other than the proposed insured; and (c) the application was completed in the presence of the proposed insured, and the applicant if other than the proposed insured, who signed it in my presence.

I recommend that the Knights of Columbus consider the risk for acceptance subject to remarks below.

Date_____ _____
Signature and I.D. Number of Writing Agent

(_____)_____
Writing Agent's Telephone Number

WRITING AGENT'S REMARKS

_____

_____

_____

_____

_____

_____

RECEIPT

The Knights of Columbus received $_____ from_____ on the date shown below. This amount was paid when a life insurance application which bears the same date as this receipt was signed in which _____is named as the proposed insured. This receipt and the Temporary Insurance Agreement set forth below are issued on the condition that any check, draft or other order or authorization for payment of money is good and can be collected.

Date: _____ _____Agent

(The above receipt must not be completed unless payment for the initial premium has been made at the time of application or unless use of existing Knights of Columbus values has been authorized. The premium check, if any, must be made payable to the Knights of Columbus. Do not make the check payable to the agent or leave the payee blank.)

TEMPORARY INSURANCE AGREEMENT

The Knights of Columbus agrees to provide Temporary Insurance as follows:

Payment of Temporary Insurance

The Temporary Insurance will be paid to the beneficiary named in the application if any person who is to be covered by the insurance contract applied for dies while the Temporary Insurance is in force.

Amount of Temporary Insurance

This Agreement provides Temporary Insurance for any person who is to be covered by the insurance contract applied for in the amount applied for on that person or $300,000, whichever is less. (See Special Limitation 1 below.)

Commencement of Temporary Insurance

The Temporary Insurance will start when all medical exams, paramedical exams, telemedical exams, laboratory tests and reports required at time of application are completed. If no exams, tests or reports are required, the Temporary Insurance will start on the date of the above Receipt.

Duration of Temporary Insurance

Unless this Temporary Insurance ends sooner for one of the three reasons listed in the Termination of Temporary Insurance section below, it will end 90 days after it starts.

Termination of Temporary Insurance

1. The Temporary Insurance will end when the Knights of Columbus issues the insurance contract as applied for.
2. The Temporary Insurance will end when the Knights of Columbus issues an insurance contract other than as applied for, and the contract is accepted by the contract owner.
3. The Temporary Insurance will end when the Knights of Columbus refunds the initial premium or restores the existing values used to pay the initial premium.

Special Limitations Applicable to Temporary Insurance Agreement

1. In the event that more than one Temporary Insurance Agreement is in force at the time of a proposed insured's death, the maximum total amount payable under all such Agreements will be $300,000.
2. If any proposed insured dies by suicide, the liability of the Knights of Columbus under this Agreement is limited to a refund of the payment made.
3. No Temporary Insurance will be provided with respect to a child to be insured under the insurance contract applied for or under a Family Insurance Rider or Children's Insurance Rider, if death occurs while such child is less than 15 days old.
4. No Temporary Insurance will be provided with respect to any proposed insured who is to be insured under an insurance contract applied for under the provisions of a Guaranteed Purchase Option Rider or a Youth Purchase Option Rider.
5. No Temporary Insurance will be provided for any insurance coverage paid for by funds transferred from another insurer as part of a Section 1035 exchange.
6. Fraud or material misrepresentation in the application invalidates this Agreement. In the event of fraud or material misrepresentation, the liability of the Knights of Columbus is limited to a refund of any payment made.
7. No change may be made in the terms and conditions of this Agreement. No statement which claims to make such a change will bind the Knights of Columbus.

NOTICE TO PROPOSED INSURED

Fair Credit Reporting Act

Federal and state laws require us to notify you that, in connection with our consideration of this application, we may request and obtain an investigative consumer report. In addition, such a report may be requested subsequently to update our records. We may also request one, if you apply for more coverage.

The report may contain information as to character, general reputation, personal characteristics and mode of living and driving record. It may be obtained through an interview with: you, an adult member of your family, friends, neighbors, business associates, other persons with whom you are acquainted, or government agencies regulating motor vehicles. The report will also consist, when applicable, of a confirmation of your age, residence, marital status, employment and the like.

You have the right, upon written request, to be informed whether or not an investigative consumer report was obtained by us. Send your request to: Medical Director, Knights of Columbus, P. O. Box 1670, New Haven, Connecticut 06510-3326. If it was obtained, we are required to furnish the name and address of the consumer reporting agency and to furnish detailed information concerning the nature and scope of the report. Where the name and address of the consumer reporting agency are furnished, the report may be inspected and a copy may be obtained by contacting the agency.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

This MIB is a non-profit organization which operates as an information exchange for its members. The Knights of Columbus is a member of the MIB.

We make reports to the MIB on factors affecting your insurability. We will not inform them of our decision on your applications. If you subsequently apply to another MIB member company for life or health insurance or submit a claim for benefits, the MIB will, upon request, supply that company with information in its files. The Knights of Columbus or its reinsurers may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon written request, the MIB will arrange disclosure of any information it may have on you in its file. If you feel the information in the MIB file is not correct, you may contact the MIB and seek a correction in accordance with procedures outlined in the Federal Fair Credit Reporting Act.

The MIB's address is: MIB, Inc., P. O. Box 105, Essex Station, Boston, Massachusetts 02112. The MIB's telephone number is: (866) 692-6901 (TTY 866-346-3642 for hearing impaired). The MIB's web address is: www.mib.com.

DESCRIPTION OF INFORMATION PRACTICES

Collection of Information

In order to properly underwrite your insurance coverage, we must collect a certain amount of necessary and helpful information. The amount and type of information collected may vary depending on the amount and type of coverage applied for. In general, we may seek information about: your age, occupation, physical condition, health history, mode of living, avocations and other personal characteristics.

You are our most important source of information, but we may also collect or verify information by contacting: medical professionals and institutions which have provided care to you or members of your family proposed for coverage, employers and business associates, friends and neighbors, and other insurance companies you have applied to. We may collect information by exchanges of correspondence, by phone, or by personal contact.

In some cases, we may ask an insurance support organization to collect information and submit an investigative consumer report to us. That organization may retain a copy of the report and may disclose its contents to others for whom it performs such services.

Disclosure of Information

In some circumstances, the Knights of Columbus will make disclosures of personal information to third parties. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed: the Medical Information Bureau, our reinsurers, our agents, and other insurance companies to which you have applied for coverage or benefits.

The above describes some of the disclosures which may be made, not disclosures which are always or even often made. In any event, the information disclosed will be only as much as is reasonably necessary to accomplish the intended purpose.

Access and Correction

There are procedures by which you can obtain access to personal information about you appearing in our files, including information contained in investigative consumer reports. We have also established procedures by which you may request correction, amendment or deletion of any information in our files which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request.

Obtaining Additional Information

We hope that you find this description of our information practices helpful. We take our responsibilities, and your rights, very seriously. If you have any further questions about the items just discussed please write to: Knights of Columbus, at P. O. Box 1670, New Haven, Connecticut 06510-3326.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-125601792*	*State:*	*Arkansas*
Filing Company:	*Knights of Columbus*	*State Tracking Number:*	*38674*
Company Tracking Number:	*4931*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application 600D 1-09*		
Project Name/Number:	*KOFC/95/95*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Certification/Notice 04/09/2008
Bypass Reason: Not applicable to this filing.
Comments:

Review Status:

Bypassed -Name: Application 04/09/2008
Bypass Reason: Not applicable to this filing.
Comments:

Review Status:

Satisfied -Name: COC 04/11/2008
Comments:
Attachment:
AR CoC.pdf

Review Status:

Satisfied -Name: Auth 04/11/2008
Comments:
Attachment:
Auth_4-08_dist.pdf

Review Status:

Satisfied -Name: RDB 04/11/2008
Comments:
Attachment:
AR RDB.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Knights of Columbus

Form Title(s): 600D-AR 1-09

Form Number(s): Insurance Application

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Richard B. Carroll
Associate General Counsel

April 7, 2008
Date

CELEBRATING 125 YEARS OF FAITH IN ACTION 1882-2007

KNIGHTS OF COLUMBUS

April 1, 2008

To: Department of Insurance

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Knights of Columbus

By: _____

Title: Associate General Counsel

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Knights of Columbus

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
600D-AR 1-09	52.1

Richard B. Carroll
Associate General Counsel

April 7, 2008
Date